ID:_____

Health Study Questionnaire

Please complete the attached questionnaire.

Your answers will be kept confidential.

Ask a staff person if you are not sure about any of the questions.

You can skip any questions you prefer not to answer.

You may be interrupted if a tester needs you for another test, but can continue to answer the questionnaire items after this interruption.

Thank you for completing the questionnaire.

ID:_____

Health Study Questionnaire

SECTION I: RESIDENCE INFORMATION

1. How many years have you lived in East Liverpool? _____ **years**

2. Address: **(Please list the addresses of the last 3 places you have lived for more than a year)**

A. Current Address:
Street address _____ From: month _____ year _____
City _____ State ___ ZIP _____ To: Present

B. Previous (most recent) address:
Street address _____ From: month _____ year _____
City _____ State ___ ZIP _____ To: month _____ year _____

C. Previous address:
Street address _____ From: month _____ year _____
City _____ State ___ ZIP _____ To: month _____ year _____

D. If you have lived at more than 3 addresses for more than 1 year, please let us know and we will provide you with a supplemental residency sheet.

3. Are you on the public water supply?
- ❑ Yes
- ❑ No

SECTION II: SYMPTOMS

Are you experiencing any of the following symptoms?
(**Please** √ and, IF YES, write in **year** started.)

ID:_____

	NO	YES	When did you experience it for the first time? (year)	How many times did you experience this in the LAST MONTH?
1. Problems sleeping	❑	❑		
2. Problems falling asleep	❑	❑		
3. Waking up too often	❑	❑		
4. Waking up too early	❑	❑		
5. Having nightmares	❑	❑		
6. Night sweats	❑	❑		
7. Difficulty waking up in the morning	❑	❑		
8. Difficulty staying awake during the day	❑	❑		
9. Awakening with muscle cramps	❑	❑		
10. Blurred vision	❑	❑		
11. Changes in handwriting	❑	❑		
12. Changes in sense of smell	❑	❑		
13. Changes in sense of taste	❑	❑		
14. Changes in walking	❑	❑		
15. Confusion or feeling lost	❑	❑		
16. Cough	❑	❑		
17. Cramping in legs	❑	❑		
18. Dark vision	❑	❑		
19. Diarrhea	❑	❑		
20. Dim vision	❑	❑		
21. Difficulty chewing	❑	❑		
22. Difficulty concentrating	❑	❑		
23. Difficulty driving because of feeling dizzy	❑	❑		
24. Difficulty getting out of chairs	❑	❑		
25. Difficulty sitting up straight	❑	❑		
26. Difficulty turning in bed	❑	❑		
27. Difficulty with skilled movements	❑	❑		
28. Difficulty writing	❑	❑		
29. Excessive perspiration	❑	❑		

Are you experiencing any of the following symptoms?
(**Please** √ and, IF YES, write in **year** started.)

	NO	YES	When did you experience it for the first time? (year)	How many times did you experience this in the LAST MONTH?
30. Excessive salivation	❑	❑		
31. Facial expression changes	❑	❑		
32. Facial muscle tightness	❑	❑		
33. Feeling anxious	❑	❑		
34. Feeling depressed	❑	❑		
35. Feeling irritable	❑	❑		
36. Feeling lightheaded or dizzy	❑	❑		
37. Fever, chills	❑	❑		
38. Hand or foot tapping	❑	❑		
39. Headaches at least twice a week	❑	❑		
40. Joint pain or swelling	❑	❑		
41. Loss of consciousness (fainting)	❑	❑		
42. Loss of coordination or balance	❑	❑		
43. Loss of muscle strength in arms/hand	❑	❑		
44. Loss of muscle strength in legs/feet	❑	❑		
45. Loss of sense of smell	❑	❑		
46. Lower tolerance for alcohol	❑	❑		
47. Metallic taste in mouth	❑	❑		
48. Migraine headaches	❑	❑		
49. Monotonous voice	❑	❑		
50. Muscle aches	❑	❑		
51. Muscle twitching	❑	❑		
52. Muscular rigidity	❑	❑		
53. Nausea not cause by something you ate	❑	❑		
54. Noticeable change in personality	❑	❑		
55. Numbness/tingling in fingers or feet, for more than one day	❑	❑		
56. Sexual dysfunction	❑	❑		
57. Shortness of breath on exertion	❑	❑		
58. Skin rash	❑	❑		

Are you experiencing any of the following symptoms?
(**Please** √ and, IF YES, write in **year** started.)

	NO	YES	When did you experience it for the first time? (year)	How many times did you experience this in the LAST MONTH?
59. Slowness of movement	❑	❑		
60. Slurred speech	❑	❑		
61. Stomach cramps / stomach pain	❑	❑		
62. Tremors or Shakiness (temporary)	❑	❑		
63. Tremors or Shakiness (long term)	❑	❑		
64. Trouble remembering things	❑	❑		
65. Urinary or Bowel incontinence	❑	❑		
66. Vomiting	❑	❑		
67. Wheezing or whistling in chest	❑	❑		
68. Weight fluctuation	❑	❑		
69. Respiratory problems on **'bad air'** days	❑	❑		
70. Bringing phlegm from chest into throat	❑	❑		
71. Dizziness when in the presence of **gas**	❑	❑		
72. Headaches when in the presence of **gas**	❑	❑		
73. Dizziness when in the presence of **paint**	❑	❑		
74. Headaches when in the presence of **paint**	❑	❑		

75. When you are driving and have just passed a light, do you worry that it was red? (please √ one)

❑ Never **(skip to 76 below)** ❑ Occasionally
❑ Rarely ❑ Frequently

A. When did you experience it for the first time? **(year)** _____

B. How many times did you experience this in the LAST MONTH? _____ **times**

76. Do you consider yourself allergic or unusually sensitive to everyday chemicals like those in household cleaning supplies, paints, perfumes, soaps, garden sprays or things like that?

❑ Yes
❑ No **(IF NO, skip to MEDICAL HISTORY section)**
❑ Not Sure/Don't' Know **(IF NOT SURE, skip to MEDICAL HISTORY section)**

77. If YES, how old were you when you first noticed this sensitivity? **_____ (age)**

IF you don't remember, did you have it:

- ❑ Entire life
- ❑ Don't remember what age, but not entire life
- ❑ Don't know/ Not sure

78. Was there something that happened when you were that age that first triggered this sensitivity?

- ❑ Yes
- ❑ No **(IF NO, skip to MEDICAL HISTORY section)**
- ❑ Not Sure/Don't' Know **(IF NOT SURE, skip to MEDICAL HISTORY section)**

79. IF YES, what was it? _____

SECTION III: MEDICAL HISTORY

Have you ever been diagnosed <u>by a doctor</u> as having any of the following illnesses or conditions?
(**Please** √ and, **IF YES**, write in the **year** when diagnosed.)

	NO	YES	Year diagnosed	Had it within the last year? No	Had it within the last year? YES	
1. Acute Bronchitis	❑	❑	_____	❑	❑	**How many times in last year?** _____
2. Pleurisy	❑	❑	_____	❑	❑	
3. Tuberculosis	❑	❑	_____	❑	❑	
4. Chest Injury	❑	❑		❑	❑	
5. Pneumonia	❑	❑	_____	❑	❑	**How many times in last year?** _____
6. Chronic Bronchitis	❑	❑		❑	❑	**How many times in last year?** _____
7. Emphysema	❑	❑	_____	❑	❑	
8. Asthma	❑	❑	_____	❑	❑	**How many times in last year?** _____
9. Hay fever	❑	❑	_____	❑	❑	

Have you ever been diagnosed <u>by a doctor</u> as having any of the following illnesses or conditions?
(**Please** √ and, **IF YES**, write in the **year** when diagnosed.)

	NO	YES	Year diagnosed	Had it within the last year? No	Had it within the last year? YES	
10. High blood pressure	❑	❑	_____	❑	❑	
11. Heart trouble	❑	❑	_____	❑	❑	
12. Heart attack	❑	❑	_____	❑	❑	**How many times in last year?** _____
13. Chest pain with exertion	❑	❑	_____	❑	❑	
14. Heart valve disease	❑	❑	_____	❑	❑	
15. Bone or joint cancer	❑	❑	_____	❑	❑	
16. Brain cancer	❑	❑	_____	❑	❑	
17. Breast cancer	❑	❑	_____	❑	❑	
18. Cancer of esophagus (swallowing tube), stomach, intestines, colon, rectum, liver, pancreas, or other digestive organs	❑	❑	_____	❑	❑	
IF YES, which type?_____						
19. Kidney or bladder cancer	❑	❑	_____	❑	❑	
20. Leukemia	❑	❑	_____	❑	❑	
21. Lymphoma or lymph system cancer	❑	❑	_____	❑	❑	
22. Lung or chest cancer	❑	❑	_____	❑	❑	
23. Multiple myeloma	❑	❑		❑	❑	
24. Male or female organ cancer	❑	❑	_____	❑	❑	
IF YES, which type?_____						
25. Mouth or throat cancer	❑	❑	_____	❑	❑	

Have you ever been diagnosed <u>by a doctor</u> as having any of the following illnesses or conditions?
(**Please** √ and, **IF YES**, write in the **year** when diagnosed.)

	NO	YES	Year diagnosed	Had it within the last year? No	YES	
26. Nasal cancer	❑	❑	_____	❑	❑	
27. Skin cancer	❑	❑	_____	❑	❑	
28. Thyroid cancer	❑	❑	_____	❑	❑	
29. Cataracts	❑	❑	_____	❑	❑	
30. Glaucoma	❑	❑	_____	❑	❑	
31. Other eye problems (not related to glasses or contacts)	❑	❑	_____	❑	❑	
IF YES, which type?_____						
32. Anemia	❑	❑	_____	❑	❑	**How many times in last year?** _____
33. Psychiatric / nervous disorder	❑	❑	_____	❑	❑	
IF YES, which type?_____						
Were you given medication?	❑	❑	_____			
IF YES, which medication?_____						
34. Seizure disorder	❑	❑	_____	❑	❑	
35. Diabetes	❑	❑	_____	❑	❑	
36. Hepatitis, jaundice or other liver disease	❑	❑	_____	❑	❑	
37. Allergies	❑	❑	_____	❑	❑	
IF YES, which type?_____						
38. Skin rashes	❑	❑	_____	❑	❑	**How many times in last year?** _____
39. Diseases of bones, joints, muscles	❑	❑	_____	❑	❑	

ID:_____

Have you ever been diagnosed <u>by a doctor</u> as having any of the following illnesses or conditions?
(**Please** √ and, **IF YES**, write in the **year** when diagnosed.)

	NO	YES	Year diagnosed	Had it within the last year? No	YES	
40. Kidney problems / infection	❑	❑		❑	❑	
41. Bladder infection	❑	❑		❑	❑	**How many times in last year?** _____
42. Cold sores or mouth ulcers	❑	❑		❑	❑	**How many times in last year?** _____
43. Blood in urine	❑	❑		❑	❑	
44. Thyroid disease	❑	❑		❑	❑	
45. Head injury	❑	❑		❑	❑	
46. Asbestosis	❑	❑		❑	❑	
47. Rheumatic fever	❑	❑		❑	❑	
48. Fainting spells	❑	❑		❑	❑	**How many times in last year?** _____
49. Sinus trouble / Sinusitis	❑	❑		❑	❑	**How many times in last year?** _____
50. Back or spine problems	❑	❑		❑	❑	
51. Swollen lymph nodes	❑	❑		❑	❑	**How many times in last year?** _____
52. Aplastic anemia	❑	❑		❑	❑	
53. Niemann-Pick's disease	❑	❑		❑	❑	
54. Alzheimer's disease	❑	❑		❑	❑	
55. Amyotrophic Lateral Sclerosis (ALS), aka Lou Gehrig's disease	❑	❑		❑	❑	
56. Huntington's chorea	❑	❑		❑	❑	
57. Multiple Sclerosis	❑	❑		❑	❑	
58. Parkinson's disease	❑	❑		❑	❑	

Have you ever been diagnosed <u>by a doctor</u> as having any of the following illnesses or conditions?
(**Please** √ and, **IF YES**, write in the **year** when diagnosed.)

	NO	YES	Year diagnosed	Had it within the last year? No	YES
59. Autoimmune Connective Tissue Disorders (Lupus, Rheumatoid arthritis)	❑	❑	_____	❑	❑
60. Tremor disorder	❑	❑	_____	❑	❑
61. Silicosis, aka Grinder's disease or Potter's rot	❑	❑	_____	❑	❑
62. Other major illness	❑	❑	_____	❑	❑

IF YES, which type?_____

63. Have you been hospitalized in the last 5 years? **No** ❑ **Yes**❑ **IF YES** what year?_____

IF YES, what was the condition? _____

If you were hospitalized more than once in 5 years, please list these below:

SECTION IV: MEDICATIONS

1. Have you taken any medication in the last 24 hours (including prescription and over-the-counter)?

❑ Yes
❑ No **(IF NO, skip to question 4)**

2. What medication(s) did you take in the last 24 hrs.?_____

3. When did you first take that medication? _____**/**_____ **(month/year)**

4. Have you taken the following **over-the-counter** medications? If YES, please write the name/brand.

ID:_____

Over-the-counter	NO	YES	If YES, please write name/brand	√ if taken in last month	If YES, how many do/did you take? Per Year	Per Month	Per Day
1. Antacids or Stomach Medicine (Maalox, Mylanta, Tums, etc.)	❑	❑	_____	❑	_____	_____	_____
2. Cough Medicine	❑	❑	_____	❑	_____	_____	_____
3. Cold Medications	❑	❑	_____	❑	_____	_____	_____
4. Skin Medications or Creams	❑	❑	_____	❑	_____	_____	_____
5. Headache Medicines	❑	❑	_____	❑	_____	_____	_____
6. Sleeping Pills	❑	❑	_____	❑	_____	_____	_____
7. Pain Medications (Aspirin, Tylenol, Advil, etc.)	❑	❑	_____	❑	_____	_____	_____
8. Iron Supplements	❑	❑	_____	❑	_____	_____	_____
9. Vitamin Supplements with Iron	❑	❑	_____	❑	_____	_____	_____
10. Herbal Medicine	❑	❑	_____	❑	_____	_____	_____
11. Other:	❑	❑	_____	❑	_____	_____	_____

5. Have you taken the following **prescription** medications? If YES, please write the name/brand.

Prescription	NO	YES	If YES, please write name/brand	√ if taken in last month	If YES, how many do/did you take? Per Year	Per Month	Per Day
1. Prescribed Antacids or Stomach Medicine	❑	❑	_____	❑	_____	_____	_____
2. Antibiotics	❑	❑	_____	❑	_____	_____	_____
3. Arthritis Medicine	❑	❑	_____	❑	_____	_____	_____
4. Blood Pressure Medicine	❑	❑	_____	❑	_____	_____	_____
5. Medications for Asthma	❑	❑	_____	❑	_____	_____	_____

Prescription	NO	YES	If YES, please write name/brand	√ if taken in last month	If YES, how many do/did you take? Per Year	Per Month	Per Day
6. Heart Medicines (for heart problems or irregular heartbeat, etc.)	❑	❑	_____	❑	_____	_____	_____
7. Cholesterol Medicines (for lowering lipid, etc.)	❑	❑	_____	❑	_____	_____	_____
8. Diabetes Medicines	❑	❑	_____	❑	_____	_____	_____
9. Eye Medications	❑	❑	_____	❑	_____	_____	_____
10. Prescribed Headache Medicines	❑	❑	_____	❑	_____	_____	_____
11. Muscle Relaxants	❑	❑	_____	❑	_____	_____	_____
12. Medicine for Depression	❑	❑	_____	❑	_____	_____	_____
13. Medicine for Anxiety	❑	❑	_____	❑	_____	_____	_____
14. Prescribed Pain Medications	❑	❑	_____	❑	_____	_____	_____
15. Parkinson's/Tremor Medication (L-DOPA, Sinemet, Azilect, Mirapex, Mysoline, etc.)	❑	❑	_____	❑	_____	_____	_____
16. Other:	❑	❑	_____	❑	_____	_____	_____

SECTION V: WORK HISTORY & BEHAVIORS

1. What is your current employment status? Please √ all that apply.

- ❑ Employed full-time
- ❑ Employed part-time
- ❑ Unemployed
- ❑ Homemaker
- ❑ Full-time student
- ❑ Part-time student
- ❑ Retired
- ❑ Disabled
- ❑ Other *(please specify)* _____

2. **<u>If you are disabled</u>,** please answer the following:

A. What date did you become disabled?___/_____ **(month/year)**

B. **How** did you become disabled?_____

_____

C. Please list any jobs and the time worked **since your disability**:

Position	**Tasks**	**Duration** (example: 1975 to 1978)

3. **If not currently employed,** are you receiving: *(please √ all that apply)*

- ❑ Not receiving any benefits/assistance
- ❑ Retirement
- ❑ Disability
- ❑ Other *(please specify)* _____
- ❑ AFDC
- ❑ General Assistance
- ❑ SSI

4. Please list your employers, starting with current or most recent employer, dates of employment, and position held:

A. _____ from____ to ____ Position_____

B. _____ from____ to ____ Position_____

C. _____ from____ to ____ Position_____

D. _____ from____ to ____ Position_____

E. _____ from____ to ____ Position_____

5. For how many months were you employed in the past 2 years? _____

6. Approximately how many days were you sick at home in the past 2 years? ____

7. Did any of your employment involve exposure to chemicals?

- ❑ Yes **(Please describe in the table below)**
- ❑ No **(Skip to question 8)**
- ❑ Not Sure/Don't' Know **(Skip to question 8)**

Employer / Position	Duration (Please list years)	Type of chemical?			
		Solvents	Pesticides	Metals	Not sure which type
_____	_____ to _____	❑	❑	❑	❑
_____	_____ to _____	❑	❑	❑	❑
_____	_____ to _____	❑	❑	❑	❑
_____	_____ to _____	❑	❑	❑	❑

Have you ever participated in any of the following hobbies?	**NO**	**YES**
8. Welding	❑	❑
9. Gardening	❑	❑
10. Painting	❑	❑
11. Ceramics/sculpting	❑	❑
12. Stained glass	❑	❑
13. Metal Work/Jewelry	❑	❑
14. Photo lab developing	❑	❑

15. Have you had chemical exposure at home or while doing hobbies (not during work)?

❑ Yes **(IF YES, please describe below)**
❑ No **(IF NO, continue with question 16)**

IF YES, please describe and indicate when (year): _____

_____

_____

_____

16. Do you currently smoke?

- ❑ Yes **(IF YES, skip to question 19)**
- ❑ No

17. Have you ever smoked more than 100 cigarettes (or 5 packs) in your life?

- ❑ Yes
- ❑ No **(IF NO, skip to question 22)**

18. When did you stop smoking? _____/_____**(month/year)**

19. At what age did you begin smoking? _____

20. For how many years did you smoke? _____ **Years**

21. How many cigarettes per day (not packs)? _____ **cigarettes**

22. Does someone in your household smoke?

- ❑ Yes
- ❑ No

23. Do you drink alcoholic beverages?

- ❑ Yes
- ❑ No **(IF NO, skip to question 31)**

24. How long have you been consuming alcoholic beverages? ___ **years**

25. For each type of alcohol below, please indicate **on average** how many days a week you drink and how much you drink on those days that you do:

Type of alcohol:	**Drink it? No**	**Yes**	**If YES, days per week**	**If Yes, drinks per day**
a. Beer (bottle)	❑	❑	_____	_____
b. Wine (glass)	❑	❑	_____	_____
c. Hard liquor (1½ oz.)	❑	❑	_____	_____

26. Has there been a change in how your body reacts to alcohol?

- ❑ Yes
- ❑ No **(IF NO, skip to question 28)**

27. Can you tolerate:

- ❑ More
- ❑ Less

28. Has there has been any change in your drinking habits?

- ❑ Yes
- ❑ No **(IF NO, skip to question 31)**

29. In what year was the change in your drinking habits? _____

30. What was the change in your drinking habits? (please √ only one)

❑ Drink more now ❑ Drink less now ❑ No longer drink

31. Please estimate the number of hours spent per day in:

	Weekday		**Weekend**	
SPRING / SUMMER	**Average # of hours per day**	**# of hours of heavy physical exertion per day**	**Average # of hours per day**	**# of hours of heavy physical exertion per day**
a. Outdoors	_____	_____	_____	_____
b. Indoors	_____	_____	_____	_____
FALL / WINTER	**Average # of hours per day**	**# of hours of heavy physical exertion**	**Average # of hours per day**	**# of hours of heavy physical exertion**
a. Outdoors	_____	_____	_____	_____
b. Indoors	_____	_____	_____	_____

32. In Spring / Summer, approximately how many **hours per day** do you **keep windows open?** _____ **hrs.**

33. In Spring / Summer, approximately how many **hours per day** do you **use an air conditioner?** _____ **hrs. (if no a/c, please enter 0)**

34. In Fall / Winter, approximately how many **hours per day** do you **keep windows open?** _____ **hrs.**

35. In Fall / Winter, approximately how many **hours per day** do you **use an air conditioner?** _____ **hrs. (if no a/c, please enter 0)**

36. On average, how many hours per night do you sleep? _____**hours**

37. In the past 12 months, have there been any major life events that have had an impact on your life (example: major illness, death of someone close)?

- ❑ Yes **(please describe in the box below)**
- ❑ No **(IF NO, skip to the DIET section below)**

38. Do you feel that this event(s) affected your physical health?

- ❑ Yes
- ❑ No

39. Do you feel that this event(s) affected your mental health?

- ❑ Yes
- ❑ No

SECTION VI: DIET

As some foods contain naturally-occurring trace levels of manganese or iron, we are interested in knowing approximately how much you consume of these types of food in order to estimate your total body burden of manganese and iron. For each of these foods, please indicate approximately how much you consume each week on average. Please also indicate the approximate number of servings you have had in the last month, and in the last 3 months.

Meat and Poultry	**Serving size**	**Approx. # of servings per week**	**Approx. # of servings in last month**	**Approx. # of servings in last 3 months**	**√ if you do not eat any**
1. Beef, chuck, lean only, braised	3 ounces				❑
2. Beef, tenderloin, roasted	3 ounces				❑
3. Beef, eye of round, roasted	3 ounces				❑
4. Pork, loin, broiled	3 ounces				❑
5. Turkey, dark meat, roasted	3½ ounces				❑
6. Turkey, light meat, roasted	3½ ounces				❑
7. Chicken liver, cooked	3½ ounces				❑
8. Chicken, leg, meat only, roasted	3½ ounces				❑
9. Chicken, breast, roasted	3 ounces				❑
Seafood	**Serving size**	**Approx. # of servings per week**	**Approx. # of servings in last month**	**Approx. # of servings in last 3 months**	**√ if you do not eat any**
10. Tuna, fresh bluefin, cooked, dry heat	3 ounces				❑
11. Tuna, white, canned in water	3 ounces				❑
12. Halibut, cooked, dry heat	3 ounces				❑
13. Oysters, breaded and fried	6 pieces				❑
14. Crab, blue crab, cooked, moist heat	3 ounces				❑

15. Shrimp, mixed species, cooked, moist heat	4 large				❑
16. Clams, breaded, fried	¾ cup				❑
Vegetables	**Serving size**	**Approx. # of servings per week**	**Approx. # of servings in last month**	**Approx. # of servings in last 3 months**	**√ if you do not eat any**
17. Spinach, cooked	½ cup				❑
18. Broccoli	½ cup				❑
19. Swiss chard	½ cup				❑
20. Bok Choy	½ cup				❑
21. Beet greens, cooked	½ cup				❑
22. Turnip greens	½ cup				❑
23. Green Beans	½ cup				❑
24. Peas	½ cup				❑
25. Potato	½ cup				❑
26. Sea Vegetables	½ cup				❑
Fruits	**Serving size**	**Approx. # of servings per week**	**Approx. # of servings in last month**	**Approx. # of servings in last 3 months**	**√ if you do not eat any**
27. Watermelon	1/8 melon				❑
28. Pineapple	1 cup				❑
29. Dried Figs	5				❑
30. Dried Apricots	5				❑
Soy Products	**Serving size**	**Approx. # of servings per week**	**Approx. # of servings in last month**	**Approx. # of servings in last 3 months**	**√ if you do not eat any**
31. Soy Beans	½ cup				❑
32. Tofu	½ cup				❑
33. Tempeh	½ cup				❑

Grains	Serving size	Approx. # of servings per week	Approx. # of servings in last month	Approx. # of servings in last 3 months	√ if you do not eat any
34. Wheat Pasta	1 cup				❑
35. Brown Rice	1 cup				❑
36. Bran Cereal	1 cup				❑
37. Oatmeal	1 cup				❑
Nuts, Seeds and Legumes	**Serving size**	**Approx. # of servings per week**	**Approx. # of servings in last month**	**Approx. # of servings in last 3 months**	**√ if you do not eat any**
38. Almonds	¼ cup				❑
39. Peanuts	3½ ounces				❑
40. Sunflower Seeds	2 Tbsp				❑
41. Pumpkin Seeds	2 Tbsp				❑
42. Pinto Beans	½ cup				❑
43. Navy Beans	½ cup				❑
44. Black eyed beans	½ cup				❑
45. Lentils	½ cup				❑
46. Chickpeas (Garbanzo Beans)	7 ounces				❑
Beverages	**Serving size**	**Approx. # of servings per week**	**Approx. # of servings in last month**	**Approx. # of servings in last 3 months**	**√ if you do not eat any**
47. Tea	1 cup				❑
48. Soy Milk	½ cup				❑
49. Tomato Juice	½ cup				❑
50. Prune Juice	½ cup				❑

51. Do you grow your own fruits or vegetables in the soil at your residence?

❑ Yes

IF YES, what percentage of the produce you eat is home-grown? _____%

❑ No

SECTION VII: ABOUT YOU

1. What is your sex?

- ❑ Male
- ❑ Female

2. What is your age? _____

3. What is your date of birth? _____**/**___**/**_____ **(month/day/year)**

4. What is your race/ethnicity?

- ❑ African-American
- ❑ Caucasian
- ❑ Hispanic/Chicano/Latino
- ❑ Asian or Pacific Islander
- ❑ Native American
- ❑ Other *(please specify)*_____

5. What is your current marital status?

- ❑ Single
- ❑ Married
- ❑ Divorced
- ❑ Widowed
- ❑ Living with significant other
- ❑ Other *(please specify)*_____

6. How many children do you have (including adopted and stepchildren)? _____

7. How many children live in your household? _____

8. Which of the following best describes the highest level of education you have attained?

- ❑ Less than 9th grade
- ❑ 9th-12th, no diploma
- ❑ High School Diploma/G.E.D.
- ❑ Some college, no degree
- ❑ Associate Degree
- ❑ 4-Yr./Bachelor's Degree
- ❑ Graduate Degree: (please circle)
  MA/MS Ph.D. MD JD

9. What was your **best** subject in school? _____

10. On average, what grades did you get in your **best** subject? _____

11. What was your **worst** subject in school?_____

12. On average, what grades did you get in your **worst** subject? _____

13. Have you ever been diagnosed with a learning disability?

- ❑ Yes **(IF YES, please specify)** _____
- ❑ No

14. Were you ever placed in a special education or remedial class?

- ❑ Yes
- ❑ No

15. Do you have health insurance?

- ❑ Yes
- ❑ No **(IF NO, skip to question 17)**

16. What type of insurance do you have?

- ❑ Private insurance
- ❑ Medicaid
- ❑ Medicare
- ❑ SSI
- ❑ Other (specify)_____

Name of insurance: _____

17. Please identify your primary doctor:

Doctor's name: _____

18. How many times have you seen a doctor or nurse in the last 12 months?_____ **Times**

19. What is your current **personal annual income** (from all sources)? *(please √one)*

- ❑ $0-9,999
- ❑ $10,000-19,999
- ❑ $20,000-29,999
- ❑ $30,000-39,999
- ❑ $40,000-49,999
- ❑ $50,000-59,999
- ❑ $60,000-69,999
- ❑ $70,000-79,999
- ❑ $80,000-89,999
- ❑ $90,000-99,999
- ❑ 100,000 or more

20. What is the annual **total income of your household**? *(please √ one)*

- ❑ $0-9,999
- ❑ $10,000-19,999
- ❑ $20,000-29,999
- ❑ $60,000-69,999
- ❑ $70,000-79,999
- ❑ $80,000-89,999

- ❑ $30,000-39,999
- ❑ $40,000-49,999
- ❑ $50,000-59,999
- ❑ $90,000-99,999
- ❑ 100,000 or more

21. How many persons were supported this past year by your total household income **indicated in question 19 above** (including yourself)? _____

If you would like us to know anything else about your experiences, please feel free to write a note in the space below.

Thank you very much for your time!